Harvard Center for
Population and Development Studies
Harvard School of Public Health

Understanding Men's Health

A Relational and Gender Sensitive Approach

Don Sabo

Working Paper Series
Number 99.14

August 1999

553
26/12

06611

The Harvard Center for
Population and Development Studies

is a university-wide research center based in Cambridge and managed by the Harvard School of Public Health. Founded in 1964, the Center's primary aim is to advance understanding of world population issues, especially those related to health, natural resources and socioeconomic development in developing countries. The Center pursues its work principally through multi-disciplinary groups of faculty, research fellows and students. Participants come from Harvard and Boston area faculties and include visiting scholars from around the world. The Center attempts to advance knowledge of world population issues through collaborative research, publications, seminars and its Working Paper Series.

Harvard Center for Popula
9 B
Cambrid

phone: 6
fax: 61
e-mail: cpds@

Community Health Cell
Library and Documentation Unit
367, "Srinivasa Nilaya"
Jakkasandra 1st Main,
1st Block, Koramangala,
BANGALORE-560 034.
Phone : 5531518

UNDERSTANDING MEN'S HEALTH

A RELATIONAL AND GENDER SENSITIVE APPROACH

Don Sabo

August 1999

Professor Don Sabo
D'Youville College
320 Porter Avenue
Buffalo NY 14201
sabo@acsu.buffalo.edu

This paper has been prepared under the Global Health Equity Initiative project on "Gender and Health Equity" based at the Harvard Center for Population and Development Studies.

505-200
06611
COMMUNITY HEALTH CELL
LIBRARY
AND
DOCUMENTATION

GLOBAL HEALTH EQUITY INITIATIVE

The working papers in the series on "Gender and Health Equity" arise from two workshops held at the Harvard Center for Population and Development Studies in 1997 and 1998. The workshops were organized as part of the Global Health Equity Initiative (GHEI), a comprehensive project on health equity funded in part by the Rockefeller Foundation and the Swedish International Development Agency. The GHEI is an interdisciplinary project that combines conceptual work on health equity with country-case studies. Other conceptual working groups, similar to the Gender and Health Equity project, are focussing on cross-cutting issues like "measurement", "ethics", and "social determinants". Some of the working papers within this series on Gender and Health Equity will appear jointly in a volume edited by Gita Sen, Piroska Ostlin and Asha George.

ABSTRACT

This paper discusses men's health within a critical feminist framework for understanding gender relations. Certain social constructions of masculinity are said to elevate men's risk for morbidity and mortality. Because gender relations are reciprocal in various institutional settings, it is argued that the gendering of men's health behaviors can also influence women's health status. A relational theory of gender and health is developed in order to illustrate a variety of positive and negative gendered health synergies between women and men. The paper concludes by discussing a relational approach to understanding men's health within the larger context of women's health movements and gender health equity.

INTRODUCTION

This working paper examines men's health from within a theoretical framework that takes gender into account. Men's health is conceptualized within a critical feminist theory of men, masculinities, and gender relations. A key argument is that certain social constructions of masculinity can be harmful to men's health. A relational analysis is also developed in order to examine synergies between men's and women's health behaviors and outcomes. The central argument is that men's and women's lives are reciprocal within larger patterns of institutional relations, and that gendered aspects of men's lives not only influence men's health outcomes, but also women's health outcomes. Finally, the study of men's health is discussed with the context of gender health equity.

THE STUDY OF MASCULINITIES, GENDER, & HEALTH

Scholars and researchers have only recently begun to study the influences of gender on men's health and illness (Lorber, 1997; Sabo and Gordon, 1995). Women's health movements emerged during the 1960's and 1970's, and by the mid-1980's, the focus on gender had become an increasingly important aspect of epidemiology, medical sociology, and interdisciplinary studies of psychosocial aspects of illness (Verbrugge, 1985; Waldron, 1983; Stillion, 1985). However, one characteristic of most of this work on gender and health was that research and theory revolved almost exclusively around women. Some early writings in "men's studies" argued that conformity to traditional masculinity often increased men's physical health risks and impoverished their emotional lives (Feigen-Fasteau, 1974; Farrell, 1975; Brannon, 1976). Sex role theory was used to argue that boys learn to adopt masculine behaviors that, in turn, heighten their susceptibility to illness or accidental death.

Critical feminist analyses of men, masculinity and health emerged as "men's health studies" during the 1990's (Sabo & Gordon, 1995). Building on a critique of sex role theory's narrow focus on gender identity, socialization, and conformity to role expectations, critical feminist thinkers emphasize that power differences shape relationships between men and women, women and women, and men and men. They also contend that gender identity and behavior are not simply imposed on individuals by socialization, but that individuals actively construct their gender identity and behavior. Gender identity is actively worked out, revamped, and maintained by individuals who are immersed in socially and historically constructed webs of power relations (Connell, 1995, 1987). Stated another way, cultural definitions of "masculinity" and "femininity" are seen as historically emergent, structurally dynamic constructs through which individuals and groups actively interpret, engage, and construct their daily behaviors and relationships (Messner, 1998; Messner and Sabo, 1995; Baca-Zinn, Hondagneu-Sotello,

Messner, 1998).

Constructions of Masculinity and Men's Health

When individuals actively participate in the construction of their gender identity and behavior, they are said to be "doing gender" (West and Zimmerman, 1987). For many boys and men in the United States, doing traditional masculinity has been associated greater risk for morbidity and mortality (Sabo, 1996; Harrison, Chu & Faracutti, 1988). Courtney's (1998a) review of recent research shows that males in the United States who harbor traditional beliefs about manhood are more likely than their nontraditional counterparts to have poor health habits (Eisler, Skidmore & Ward, 1988), to experience higher rates of depression and psychological stress (Eisler & Blalock, 1991; Good & Mintz, 1990; Sharpe & Heppner, 1991; Oliver & Toner, 1990), and to have greater cardiovascular reactivity in stressful situations (Lash, Eisler & Schulman, 1990). Helgeson (1995) found that, when diagnosed and treated for coronary heart disease, men with negatively masculine traits discussed their heart problems less often with family members, and were more likely to engage in poor health behaviors and have impaired social networks.

Identification with traditional masculinity has been linked to the three leading causes of death among United States males aged 15-34 years; i.e., unintentional injury, homicide, and suicide (*Morbidity and Mortality Weekly Report*, 1994). Stillion (1995) argues that young men's efforts to appear tough often leads them to ignore safety guidelines on the job, while others drive recklessly as an act of bravado. Men's fascination and respect for violence is often tied up with proving their manhood which, in part, explains their greater risk for homicide than females (Stillion, 1995; Staples, 1995; Reed, 1991). Suicide data show that men attempt suicide less often than women but are more likely to die than women. Stillion (1995) infers that the disparity stems partly from the fact that often males select more violent methods and, compared with females, they see surviving a suicide attempt "as yet another failure, a mark against their masculine adequacy..." (p.52). Canetto's (1995) research found that traditionally masculine expectations elevated the likelihood of a successful suicide for some men.

Courtenay (1998a, b, c) observes that some risk behaviors are culturally defined as "masculine" and, furthermore, that males use unhealthy behavior to define their manhood. For example, males may engage in excessive alcohol consumption in order to display allegiance to the male peer group (Isenhart & Silversmith, 1994). In many traditional men's sports such as rugby, boxing, or football, the masculine codes glorify pain and injury, encouraging athletes to sacrifice their bodies in order to win at all costs (Sabo, 1994). Traditional gender scripts for men can contribute to unhealthy behaviors. As Courtenay (1998a) writes:

> A man who does gender correctly would be relatively unconcerned about his health and well-being in general. He would see himself as stronger, both physically and emotionally, than most women. He would think of himself as independent, not needing to be nurtured by others. He would be unlikely to ask others for help. He would spend much time out in the world and away from home. The intense and active stimulation of his senses would be something he would come to depend on. He would face danger fearlessly, take risk frequently, and have little concern for his own safety (p. 21).

Not all "masculine traits" or forms of masculinity present dangers to men's health. Indeed, men are not all alike, nor do all men have the same stakes in maintaining traditional definitions of masculinity. At any given historical moment, there are competing masculinities--some dominant, some marginalized, and some stigmatized--each with its respective structural, psychosocial, and cultural moorings. Connell (1987) uses the term "hegemonic masculinity" to refer to the prevailing, most lauded, idealized, and valorized form of masculinity in an historical setting. In the United States hegemonic masculinity accentuates male dominance over women, physical strength, aggressiveness, violence proneness, emotional inexpressivity, and competitiveness. In this context, just as men's identification with hegemonic masculinity varies, so too does the extent of health risks associated with traditional masculinity. The challenge for men's health studies is to better understand how certain types of masculine behaviors or traits within a specific culture or institution are correlated with risky behavior and illness.

It is also important to recognize that men not only construct their gender identity with reference to masculinity, but also in relation to women and cultural definitions of femininity. Connell's concept of "emphasized femininity" refers to the cultural ideal that is celebrated for women; i.e., sociability, fragility, passivity, compliance with male desire, and sexual receptivity. Emphasized femininity is constructed in reciprocal and subordinated relation to hegemonic masculinity in ways that reinforce masculine power and male-dominated hierarchies within varying institutional settings. Young males learn that adopting "feminine" forms of behavior can lead to ridicule or stigma and, they sometimes engage in risky behaviors in order to avoid being labeled feminine or effeminate: e.g., an adolescent male gets into fights to keep from being labeled a "sissy", or a middle-aged male hides his chest pains to evade appearing "soft" to his fellow workers.

Constructions of Masculinity and Women's Health

The health risks incurred by men's pursuit of masculinity and/or avoidance of femininity do not simply influence *male* morbidity and mortality. The gendering of men's health behaviors also generates

consequences for *women's* health status. For example, Pleck, Sonenstein and Ku (1992) interviewed a national sample of adolescent, never-married United States males aged 15-19 between 1980 and 1988. Hypothesis tests were geared to assessing whether "masculine ideology" (which measured traits associated with hegemonic masculinity) put boys at risk for an array of problem behaviors. They found that masculine ideology was associated with being suspended from school, drinking and use of street drugs, frequency of being picked up by the police, being sexually active, the number of heterosexual partners in the last year, and tricking or forcing someone to have sex. These kinds of behaviors, which are in part expressions of hegemonic masculinity, elevate boys' risk for sexually transmitted diseases, HIV transmission, and early death by accident or homicide. *At the same time*, however, these behaviors encourage the victimization of women through men's violence, sexual assault, unwanted teenage pregnancy, and sexually transmitted diseases (Sabo, 1998a).

Courtenay (1998b) provides another example of how gendered constructions of men's health behaviors can influence women's health outcomes. He argues that many self-care practices in the United States are culturally framed as "feminine". Whereas mothers often teach girls about their bodies and girls learn self-care through regular physical and reproductive health exams, boys are typically unschooled in these areas. Females make more health care visits than males, even after controlling for reproductive health care visits (Kandrack, Grant & Segall, 1991; Verbrugge, 1988). Research shows that girls are encouraged to be dependent while boys are taught to be independent, and that boys receive less physical and emotional succor than girls do (Lytton and Romney, 1991). Boys are often discouraged from seeking help from their parents (Fagot, 1984). Roter and Hall's (1997) review of research on physician-patient communication showed that female patients are better informed about their ailments than male patients. In short, the construction of masculinity in United States culture does not generally promote self-nurturing attitudes or behaviors among males. It is often women, therefore, who are culturally charged to care for sick boys and men in addition to themselves. This can place an unfair burden on mothers, wives, or girlfriends for maintaining the men's health as well as their own.

It is these latter relational aspects of men's and women's health that have received the least attention from scholars who study gender and health. To date, most of the work on how gender influences health and illness has been *within sexes* rather than *between the sexes*, a split in research and theory that is reflected in the separate labels "women's health" and "men's health" (Sabo & Gordon, 1995). And yet, as Rathgeber & Vlassoff (1993) observe, "A gender approach to disease examines both the differential impact on women and men and also the social, cultural and economic contexts within which they live and work" (pp. 513-14). Critical feminist approaches are consistent with this view, but also point toward a relational analysis that explores the interrelationships between women's and men's health behaviors and outcomes.

RECIPROCALITY AND GENDERED HEALTH SYNERGIES

Women's and men's lives are fundamentally reciprocal and must be understood in relational terms. The concept of reciprocality developed in this section is used to show how women's and men's health are often relational in process and outcome.

The lives of the sexes unfold within social, cultural, and historical contexts. When men and women follow the socially prescribed masculine and feminine scripts, their actions reflect and reproduce institutional arrangements that are based on sex category (West & Zimmerman, 1987). As Connell (1987) puts it, each person occupies a niche in the larger "gender order", which is defined as the "historically constructed pattern of power relations between men and women and definitions of femininity and masculinity" (p. 231). Gender relations emerge and are transformed within varying institutional contexts that take shape within specific institutional settings such as the military, education, or marriage and family. Gender identity and individual displays of masculine or feminine cultural practices, therefore, are better understood as expressions of wider institutional processes that engage both sexes, not just one sex in isolation.

The following examples show how the health of each sex is influenced by sociocultural synergies between the sexes. A *positive gendered health synergy* exists where the pattern of gender relations promotes favorable health processes or outcomes for both sexes. A *negative gendered health synergy* occurs where the pattern of gender relations is associated with unfavorable health processes or outcomes for one or both sexes.

Men's Involvement in Pregnancy and Child Care: A Positive Gendered Health Synergy

As women have become more involved with the work sector, they have pressed men to take on a fair share of housework and child care. However, men's contributions to domestic labor and parenting have not approached parity and many women find themselves returning from jobs outside the home only to do most of housework and child care (Hochschild, 1989). Bird and Fremont (1991) found that women's greater time investment in housework was related to poorer self-reported health. Men's failure to share housework means that female partners often have less time to devote to health-inducing exercise and physical activity (Sabo and Snyder, 1993). In developing nations, women's growing involvement in the informal and formal economic sector is associated with elevated risk for morbidity and, once becoming sick, women often have less opportunity to rest and recover (Vlassoff & Bonilla, 1994).

Some health advocates have called for changes in conjugal roles that would alleviate these negative gendered health synergies. Swedin (1996) suggests that overall family health is more likely to issue when spouses adopt a partnership model for negotiating the combined demands of child care and

occupational involvement. His research showed that, when men participate in "father training" groups, they were more likely to develop closer bonds with wives and healthier relationships with their children. Few couples achieve the ideal of "shared parenthood", however, and one reason is that men often do not have a clear view of what role to play in relation to pregnancy, childbirth, and child care. Nonetheless, policies calling for "shared parenthood", "father training", or "paid parental leave" appear to make sense with regard to *both* women's and men's health.

Prison as a Pocket of Risk: A Negative Gendered Health Synergy

Rates of imprisonment vary around the world. Nearly 1.6 million persons are imprisoned in the United States (600/100,000), compared with 1.2 million in China (103/100,000), and 1 million in Russia (690/100,000). Prison populations tend to be disproportionately male, economically impoverished, and in some nations, mostly racial and ethnic minorities. In the United States, Blacks comprise 50% of the male prison population, and Hispanics another 15% (Miller, 1996; Mauer, 1995). Prisons are also gendered institutions (Carrabine & Longhurst, 1998), exhibiting earmarks of patriarchal institutions such as sex segregation, hierarchical relationships, and social control through aggression and violence (Sabo, Kupers & London, forthcoming). The gendering of prison life is also evident in the constructions of masculinity among prisoners that revolve around a male code for acting tough, being prepared to fight, avoiding intimacy, minding one's own business, and avoiding feminine behaviors (Kupers, 1999; Newton, 1994). The cultural trappings of hegemonic masculinity are also present in the current call by politicians for harsher punishments of prisoners and the move away from rehabilitative approaches.

Epidemiologically, the North American corrections system acts as a whirlpool of risk for many men who, even before they are arrested and jailed, reside in structurally disadvantaged communities where poverty, unemployment, and racial oppression already yield higher morbidity and mortality rates (e.g., tuberculosis, hepatitis, and AIDS) (Polych & Sabo, forthcoming). Because of unhealthy prison conditions, they are yet again exposed to heightened risk for illness (Toepell, 1992; Bellin, Fletcher & Safyer, 1993; Kupers, 1999). For example, the incidence of active tuberculosis among New York State prisoners went from 15/100,000 in the 1970's to 139/100,000 in 1993, while 58% of new TB infections among medical personnel working with these inmates were attributed to occupational exposure (Steenland, Levine, Sieber, Schulte & Aziz, 1997). A study of New York City jails, where the average inmate stay is 65 days, found that one year of jail time doubled the probability of contracting TB. The authors expressed concerns that, should a multi-drug resistant strain of TB enter the jail system, the resulting infection would be rapidly transmitted to the wider urban population as inmates returned to their homes (Bellin, Fletcher & Safyer, 1993). In addition, despite the realities of man-on-man sexual relations (both consensual sex and rape) and iv-drug use in prisons, inmates are rarely provided with condoms or

clean needle works, thus elevating risk for contagious disease (Cummings, 1991; Expert Committee, 1994).

The failure of corrections institutions to provide health education and effective treatment interventions is putting prisoners at greater risk for disease as well as the public at large (Courtenay and Sabo, forthcoming; Polych & Sabo, 1995). Prisons are not sealed off from their surrounding communities, and men constantly move in and out of the corrections system, oftentimes carrying physical or mental illness with them. The average prison sentence in the United States is less than five years, and about 95% of all prisoners are eventually released, despite the trends toward longer sentences (Kupers, 1999). Upon release, many infected male prisoners return to communities in which poor and racially oppressed populations of *both* males and females already exhibit disproportionately higher rates of HIV infection and AIDS (Zierler & Krieger, 1997). The cycles of risk and infection grind forward.

Despite the World Health Organization's call for greater therapeutic and rehabilitative corrections practices, American prison policies continue to emphasize punishment and endanger the public health. Negative gendered health synergies are set into motion through which punitive, predominantly male prison administrators maintain policies and conditions that jeopardize the health of male prisoners and corrections staff, and concomitantly, the women and children in their lives.

Extramarital Sex and Contagion: Negative Gendered Health Synergies

A variety of studies of sexually transmitted infection reveal a pattern of gender relations and reciprocal constructions of masculinity and femininity that constitute negative gendered health synergies. Zambrana (1997) conducted focus groups on conjugal sexual practices with lower-middle-class professional men who worked in Bolivian non-government organizations. The men said they were bored with conjugal sex, and that their wives "just lay there". Yet they also admitted that they would be disconcerted by expressions of sexual innovation or autonomy by their wives, perhaps suspecting them of extramarital sexual involvement. Within Bolivian culture, while men learn to be sexual initiators and active coital participants, women generally internalize feminine cultural expectations that call for sexual passivity and virgin like chastity.

The cultural scripting of conjugal sexual relations in accordance with masculine agency and feminine passivity among these Bolivian couples was associated with elevated risk for sexually transmitted disease for *both* sexes. Many men reported seeking sexual excitement outside marriage with girlfriends or prostitutes in order to satisfy their urges. That extramarital sexual activity was a shared cultural expectation among the men was evidenced by the fact that some of those who did not engage in extramarital sex reported telling their friends that they had done so, in order to affect masculine adequacy. Concomitantly, wifely conformity to passive femininity may have lowered women's willingness to

confront or question their husbands about extramarital sex or their sexual practices with other women. The lack of communication around sexual practices might have been further blocked by the men's need for control in their marriage. In the end, the reciprocal constructions of conjugal sexualities around masculine agency and feminine passivity merged to elevate risk for sexually transmitted infections for both spouses and in the larger community, as well as maintaining male hegemony with reference to both marriage and sexuality.

A study of the cultural practices used by Zimbabwe women and men to prepare for sex reveals clear linkages between gender identity construction, sexual behavior, and transmission of HIV (Ray, Gumbo, & Mbizvo, 1996). The researchers describe how men's perceptions of coitus and masculine potency, and reciprocally, women's use of vaginal drying agents and passive compliance to gearing the sex act to evoke male pleasure, are putting women directly at risk for reproductive tract infection and HIV. Meanwhile, caught up in the migrant labor system spawned by development, the men work in towns, factories, or mines and periodically visit their ancestral homes in villages which are maintained by wives. The husbands' sexual relationships with girl friends and prostitutes while away from home puts them at risk for contracting STD's and HIV, which they carry back to the conjugal bed. In short, the authors point to a confluence of etiological factors and patterned gender relations that promote sexually transmitted infection among some Harare couples.

Gender inequality and gender expectations are also implicated in HIV transmission among women in the United States (Zierler & Krieger, 1997). The number of AIDS cases among American women who were infected through having sex with men grew during the 1990's (Centers for Disease Control, 1998). Several studies show that women who are dependent on male partners for social status or economic support are less apt to expect or negotiate condom use (Pivnick, 1993; Wyatt & Dunn, 1991). Psychological dependence on male partners (e.g., feelings of isolation, powerlessness) have also been associated with women's reluctance to discuss risk reduction practices (Amara, 1995). Reciprocally, men's economic advantage over women partners and presumed masculine superiority may give them a sense of sexual entitlement that precludes adoption of safer sex practices.

Despite cross-cultural differences, the above studies show how reciprocal constructions of gender identity and behavior inform sexual conduct between males and females in ways that elevate health risks for both sexes.

Gender Equity in Athletics and Women's Health: Mixed Gendered Health Synergies

The numbers of girls participating in sports and fitness activities in many post-industrial nations has mushroomed in recent decades. In the United States girls now comprise about 37% of high school athletes, representing an increase from 1 in 27 girls who participated in 1971 to 1 in 3 girls in 1994. The

ratio for boys during this time frame remained constant at 1 in 2. In 1994-95, 2,240,000 girls participated in high school sports, compared to 3.554,429 boys, 37% and 63% respectively (National Federation of State High School Association, 1995-1996).

The President's Council on Physical Fitness and Sports (1997) published an interdisciplinary report on the connections between physical activity and well-being in girls' lives. Increased physical activity was positively associated with girls' musculo-skeletal and cardiovascular functioning, psychological well-being, relationships with friends and family, and performance in school. Athletic participation has also been correlated with reduced risk for teen pregnancy among females (Sabo, et al, 1998; Miller et al, 1998; Zill, Nord & Loomis, 1995). When sport programs are organized effectively, they can Abe a developmental aid and public health asset for girls and, by inference, for boys as well" (Sabo, 1997, p. xxvii).

Despite the increases in female participation and legislative mandates for equality of opportunity in athletics in the United States, the struggle for gender equity in athletics continues. Political resistance on the part of male elites in sports organizations and gender stereotypes about male athleticism and female frailty continue to thwart efforts to secure gender equity in sport (Cahn, 1994; Hargreaves, 1994), and the resulting barriers to girls' and women's physical activity can be considered a negative gendered health synergy.

At the same time, however, positive gendered health synergies between women and men are also operating in United States sport. For example, legislation supporting gender equity in American athletics was drafted by *both* women and men members of congress. Increasing numbers of male school administrators, coaches, and athletic directors are pursuing greater athletic opportunities for girls. Males are bringing law suits on behalf of their daughters, teams, or clients. Finally, public health advocates in Kenya, Mali, and Vietnam are using community or school athletic programs as a social nexus to convey messages to youth of both sexes about HIV transmission and other reproductive health matters (Brady, 1998). Government-backed sport programs and policies in Australia, Great Britain, Northern Ireland, New Zealand, Scotland and Wales are developing quality sporting opportunities for girls and boys as a preventative health strategy (Ogle, 1997).

CONCLUSION

Garcia-Moreno (1998) writes that the "purpose of gender analysis is...to identify, analyze and act upon inequalities that arise from belonging to one sex or the other, or from the unequal power relations between the sexes". Consonant with this goal, this chapter has used critical feminist theory in order to discuss men's health issues within the context of the larger gender order.

Advocates for gender perspectives in health have generally sought to improve health equity by

ensuring that the sexes receive similar levels and quality of health care services, by fostering research on women's health and program evaluation, and by securing comparable resource allocation to meet women's health needs (Whitehead, 1992). In this way, proponents of gender health equity call for more "gender aware" policies, but their messages are not always heard by the males who predominate in the leadership and planning circles of national and international health governance organizations (Pfrannenschmidt & McKay, 1997).

Some men are skeptical of efforts to increase resources for women's health. When viewed as an outcome measure, they point to data showing greater longevity for women that seem to confound or undermine women's call for prioritizing women's health initiatives. The surface question becomes whether the appeals for more resources for women's health should be heeded in light of men's greater mortality? This type of thinking, however, reveals a tendency to see issues of gender equity in categorical and binary terms; i.e., men versus women. Moreover, it places more importance on biological health outcomes independent of the social processes that influence health and well-being.

When these concerns about men's greater mortality rates enter the dialogue around gender health equity, women's health advocates sometimes infer that a focus on men's health could undermine the rationale for gender health equity; e.g., a heightened concern for men's health might detract from women's efforts to secure greater awareness and resource allocation for women's health needs. However, the basic question should be: how can the study of men's health be integrated into a theory of women's health or gender and health? Or as Sabo and Gordon (1995) ask, "How can men's health studies position itself in relation to women's health studies, women's studies, gender studies, or the feminist paradigm?" (p. 16). Politically, the issues generally revolve around finding a place for men within feminist theory and practice, and more specifically, mapping out men's roles in relation to women's health movements.

This chapter presented a gender-sensitive analysis of men's health by examining how constructions of masculinity sometimes influence men's health outcomes. Furthermore, the gendering of men's health behaviors and outcomes was also shown to influence women's health status. A relational framework was developed in order to explore both positive and negative gendered health synergies between the sexes. Finally, men's health advocates can adopt a woman-centered orientation by learning more about how programs and policies impact the gendered health synergies between the sexes as well as within each sex.

A great deal of emphasis has been placed on gender differences in epidemiological and sociological writings on health, whether in developed or developing countries (MacIntyre, Hunt & Sweeting, 1996). Research has been typically geared to identifying differences in the health of women and men and then theorizing their etiology. The emphasis on gender differences has been highly useful but, perhaps, it has also deflected research on some of the similarities between women's and men's health

risks or, in the context of this chapter, the relational character of gendered health synergies that can positively or negatively influence the health outcomes of both sexes.

A relational framework fosters understanding of the interdependencies between women's and men's lives and respective health statuses. Finally, relational approaches can also bring men's health issues into the dialogue around gender health equity in ways that do not erode sensitivity and commitment to women's health issues and policy agendas.

11 SAS·200
06611
COMMUNITY HEALTH CELL
LIBRARY
AND
DOCUMENTATION
UNIT

REFERENCES

Amaro, H. (1995). "Love, sex and power." *American Psychology*, 50: 437-47.

Babbie, E. (1998). "The Practice of Social Research." New York: Wadsworth.

Baca Zinn, M., Hondagneu-Sotelo & Messner, M. (Eds.) (1997). *Through a Prism of Difference: Readings on Sex and Gender*. Boston: Allyn & Bacon.

Bellin, E.Y., Fletcher, D.D. & Safyer, S.M. (1993). "Association of tuberculosis infection with increased time in or admission to the New York City jail system." *Journal of the American Medical Association*, 269(17):2228-2231.

Brady, M. (1998). "Laying the foundation for girls' healthy futures: Can sports play a role?" *Studies in Family Planning*, 29(1):79-82.

Brannon, R. (1976). "The male sex role." In: D.S. David & R. Brannon (Eds.) *The Forty-nine Percent Majority*. Reading, MA: Addison-Wesley.

Cahn, S. K. (1994). *Coming On Strong: Gender and Sexuality in Twentieth-Century Women's Sport*. New York: The Free Press.

Canetto, S.S. (1995). "Men who survive a suicidal act." In: Sabo, D. & Gordon, D. (Eds.) (1995). *Men's Health and Illness: Gender, Power and the Body*. Thousand Oaks, CA: SAGE Publishers, pp. 292-304.

Carrabine, E. & Longhurst, B. (1998). "Gender and prison organization: Some comments on masculinities and prison management." *The Harvard Journal*, 37(2): 161-176.

Chang, I. (1997). *The Rape of Nanking*. NY: Penguin Books.

Connell, R. W, (1987). *Gender and Power*. Stanford: Stanford University Press.

Connell, R. W. (1995). *Masculinities*. Berkeley, CA: University of California Press.

Courtenay, W. (1998a). "Constructions of masculinity and their influence on men's well-being: A theory of gender and health." *Social Science and Medicine* (final stages of review).

Courtney, W. (1998b). *It's Better to Die Than Cry? A Longitudinal and Constructionist Study of Masculinity and Health Risk Behavior of Young American Men*. University Microfilm International. Publication # 9902042.

Courtney, W. (1998c). "College Men's Health: An Overview and a Call to Action." *Journal of American College Health*, 46 6:279-290.

Courtenay, W. & Sabo, D. (forthcoming). "Preventive health strategies for men in prison." In: D. Sabo, T. Kupers & W. London (Eds.) *Confronting Prison Masculinities: The Gendered Politics of Punishment*. Philadelphia: Temple University Press.

Cummings, C. (1991). "AIDS education in California prisons." *California AIDS Clearinghouse Reviewer*, 3(1):1-3.

Digby, T. (1998). *Men Doing Feminism*. New York: Routledge.

Doyal, L. (1996). "The politics of women's health: Setting a global agenda." *International Journal of Health Services*, 26(1):47-65.

Dowsett, G. W. (1996). "I'll show you mine if you'll show me yours." *Reproductive Health Matters*, May (7):19-24.

Eisler, R.M. & Blalock, J.A. (1991). "Masculine gender role stress: Implications for the assessment of men." *Clinical Psychology Review*, 11, 45-60.

Eisler, R.M., Skidmore, J.R. & Ward, C.H. (1988). "Masculine gender-role stress: Predictor of anger, anxiety, and health-risk behavior." *Journal of Personality Assessment, 52*(1):133-141.

Evans, T. (1998). Introduction. Gender and Health Equity Workshop: Global Health Equity Initiative. Cambridge, MA: Harvard Center for Population and Development Studies, May 26.

Expert Committee on AIDS and Prison (1994). HIV/AIDS in prisons: Summary report and recommendations of The Expert Committee on AIDS and Prisons (Ministry of Supply and Services Canada Catalogue No. JS82-68/2-1994), Ottawa, Ontario: Correctional Service of Canada.

Fagot, B.I. (1984). "Teacher and peer reactions to boys' and girls' play styles." *Sex Roles*, 11:691-702.

Farrell, W. (1975). *The Liberated Man: Beyond Masculinity*. New York: Random House.

Feigen-Fasteau, M. (1974). *The Male Machine*. New York: McGraw-Hill.

Garcia-Moreno, C. (1998). "Gender and Health: Technical Paper." World Health Organization.

Good, G.E. & Mintz, L.B. (1989). "Gender role conflict and depression in college men: Evidence for compounded risk." *Journal of Counseling and Development*, 69(1):17-21.

Harding, S. (1986). *The Science Question in Feminism*. Ithaca, NY: Cornell University Press.

Hargreaves, J. (1994). *Sporting Females: Critical Issues in the History and Sociology of Women's Sports*. London: Routledge.

Helgeson, V.S. (1995). "Masculinity, men's roles, and coronary heart disease." In: D. Sabo & D. Gordon (Eds.) *Men's Health and Illness: Gender, Power & the Body*. Thousand Oaks, CA: SAGE Publishers, pp. 68-104.

Hochschild, A. (1989). *The Second Shift: Working Parents and the Revolution at Home*. New York: Viking.

Hooks, b. (1989). *Talking Back: Thinking Feminist, Thinking Black*. Boston: South End Press.

Hubbard, R. (1990). *The Politics of Women's Biology*. New Brunswick, NJ: Rutgers University Press.

Isenhart, C.E. & Silversmith, D.J. (1994). "The influence of traditional male role on alcohol abuse and the therapeutic process." *Journal of Men's Studies*, 3(2): 127-135.

Kandrack, M., Grant, K. R. & Segall, A. (1991). "Gender differences in health related behaviour: Some unanswered questions." *Social Science and Medicine*, 32, 579-90.

Kimmel, M. & Messner, M. (1997). *Men's Lives*. New York: MacMillan.

Kupers, T. (1999). *Prison Madness*. San Francisco: Jossey-Bass Publishers.

Lash, S.J., Eisler, R.M. & Schulman, R.S. (1990). "Cardiovascular reactivity to stress in men: Effects of masculine gender role stress appraisal and masculine performance challenge." *Behavior Modification*, 14(1):3-20.

Lorber, J. (1997). *Gender and the Social Construction of Illness*. Thousand Oaks, CA: SAGE Publishers.

Lytton, H. & Romney, D.M. (1991). "Parents' differential socialization of boys and girls: A meta-analysis." *Psychological Bulletin*, 109:267-96.

Mauer, M. (1995). "Young black Americans and the criminal justice system: Five years later." Washington, D.C.: The Sentencing Project.

McIntyre, S., Hunt, K. & Sweeting, H. (1996) "Gender differences in health: Are things really as simple as they seem?" *Social Science Medicine*, 42(4):617-624.

Messner, M. (1998). *Politics of Masculinities: Men in Movements*. Thousand Oaks, CA: SAGE Publishers.

Messner, M. & Sabo, D. (1994). *Sex, Violence and Power in Sports: Rethinking Masculinity*. Freedom, CA: Crossing Press.

Messner, M. & Sabo, D. (1990). *Sport, Men and the Gender Order: Critical Feminist Perspectives*. Champaign, IL: Human Kinetics Publishers.

Meyer, I. (1995). "Minority stress and mental health in gay men." *Journal of Health and Social Behavior*, 36(1):38-56.

Meyer, I.H. & Dean, L. (1998). "Internalized homophobia, intimacy, and sexual behavior among gay and bisexual men." In: G.M. Herek (Ed.) *Stigma and Sexual Orientation: Understanding Prejudice against Lesbian, Gay Men, and Bisexuals*. Thousand Oaks, CA: SAGE.

Miller, J. G. (1996). *Search and Destroy: African-American Males in the Criminal Justice System*. New York: Cambridge University Press.

Miller, K.E., Sabo, D., Farrell, M.P., Barnes, G.M., Melnick, M.J. (1998). "Athletic participation and sexual behavior in adolescents: The different worlds of boys and girls." *Journal of Health and Social Behavior*.

Moser, C.O.N. (1993). *Gender Planning and Development: Theory, Practice, and Training*. London: Routledge.

Mydans, S. (1998). "Indonesians report widespread rapes of Chinese in riots." *The New York Times* (June 20).

National Federation of State High School Association (1995-1996). "The national federation of state high school association handbook, 1995-1996." Kansas City, MO: NSFHSA.

National Sporting Goods Association (1992). "Fitness in America-1991." International Headquarters, 1699 Wall Street, Mt. Prospect, IL 60056-5780.

National Sporting Goods Association (1995). "Sport participation study." Mt. Prospect, IL: Author.

Newton, C. (1994). "Gender theory and prison sociology: Using theories of masculinities to interpret the sociology of prisons for men." *Harvard Journal*, 10: 193-202.

Ogle, S. (1997). "International perspectives on public policy and the development of sport for young people." In: Kremer, J., Trew, K. & Ogle, S. (Eds.), *Young People's Involvement in Sport*. New York: Routledge, pp. 211-231.

Oliver, S.J. & Toner, B.B. (1990). "The influence of gender role typing on the expression of depressive symptoms." *Sex Roles*, 22(11/12):775-790.

Ostergaard, L. (1992). *Gender and Development*. London: Routledge.

Polych, C. & Sabo, D. (forthcoming). "Sentence--Death by lethal injection: IV-drug use and infectious disease transmission in North American prisons." In: D. Sabo, T. Kupers & W. London (Eds.) *Confronting Prison Masculinities: The Gendered Politics of Punishment*. Philadelphia: Temple University Press.

Polych, C. & Sabo, D. (1995). "Gender politics, pain, and illness: The AIDS epidemic in North American prisons." In: D. Sabo & D. Gordon (Eds.), *Men's Health & Illness: Gender, Power & the Body*. Thousand Oaks, CA: SAGE Publishers, 139-157

Parker, R & Terto, Jr., V. (Eds.) (1998). *Entre Homens: Homossexualidade e AIDS no Brasil*. Rio de Janeiro: ABIA.

Pfannenschmidt, S. & McKay, A. (1997). "Through a gender lens: Resources for population, health and nutrition projects." Women's Studies Project Family Health International, the Gender Working Group, Population, Health and Nutrition Center, U.S. Agency for International Development (draft, June).

Pivnick, A. (1993). "HIV infection and the meaning of condoms." *Cultural Medical Psychiatry*, 17:431-53.

Pleck, J.H., Sonenstein, F.L., & Ku, L.C. (1994). "Problem behaviors and masculinity ideology in adolescent males." In: R. Kettelhaus & M. E. Lamb (Eds.). *Adolescent Problem Behaviors: Issues and Research*. Hillsdale, NJ: Lawrence Erlbaum Associates.

The President's Council on Physical Fitness and Sports (1997). "Physical Activity & Sport in the Lives of Girls: Physical & Mental Health Dimensions from an Interdisciplinary Approach." Washington, D.C.: President's Council on Physical Fitness and Sports.

Rathgeber, E. M. & Vlassoff, C. (1993). "Gender and tropical diseases: A new research focus." *Social Science Medicine*, 37(4):513-520.

Ray, S., Gumbo, N. & Mbizvo, M. (1996). "Local voices; What some Harare men say about preparation for sex." *Reproductive Health Matters* 7(May):34-45.

Reed, W.L. (1991). "Trends in homicide among African Americans." *Trotter Institute Review*, 5:11-16.

Rosenblum, K E. & Travis, T.C. (1996). *The Meaning of Difference: American Constructions of Race, Sex and Gender, Social Class, and Sexual Orientation*. New York: McGraw-Hill.

Roter, D.L. & Hall, J.A. (1997). *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*. Westport, CT: Auburn House.

Rothenberg, P. S. (1995). *Race, Class, and Gender in the United States: An Integrated Study*. New York: St. Martin's Press.

Sabo, D., Kupers, T. & London, W. (Forthcoming). *Confronting Prison Masculinities: The Gendered Politics of Punishment*. Philadelphia: Temple University Press.

Sabo, D., Miller, K., Farrell, M.P., Barnes, G. & Melnick, M. (1998). "The Women's Sports Foundation Report: Sport and Teen Pregnancy." East Meadow, NY: Women's Sports Foundation.

Sabo, D. (1998a). "Masculinities and men's health: Moving toward post-Superman era prevention." In: M. Kimmel & M. Messner (Eds.) *Men's Lives (4th edition)*, Boston: Allyn & Bacon, pp. 347-361.

Sabo, D. (1998b). "Women's athletics and the elimination of men's sports programs." *Journal of Sport & Social Issues*, 22(1):27-31.

Sabo, D. (1996). "Caring for men." In: Cookfair, J. M. (Ed.) *Nursing Care in the Community*. St. Louis, MO: Mosby, pp. 345-365.

Sabo, D. (1997). *The Women's Sports Foundation Gender Equity Report Card: A Survey of Athletic Opportunity in American Higher Education*. East Meadow, NY: Women's Sports Foundation.

Sabo, D. & Gordon, D. (1995). *Men's Health and Illness: Gender, Power and the Body*. Thousand Oaks, CA: SAGE Publishers.

Sabo, D & Snyder, M. (1993). *Sports and Fitness in the Lives of Working Women*. East Meadow, New York: The Women's Sports Foundation.

Sabo, D. & Panepinto, J. (1990). "Football ritual and the social reproduction of masculinity." In: Messner, M. & Sabo, D. (Eds.) *Men, Sport and the Gender Order: Critical Feminist Perspectives*. Champaign, IL: Human Kinetics Publishers, pp. 115-126.

Sharpe, M.J. & Heppner, P.P. (1991). "Gender role, gender role conflict and psychological well-being in men." *Journal of Counseling Psychology*, 38:323-330.

Staples, R. (1995). "Health among African American males." In: D. Sabo & D. Gordon (Eds.). *Men's Health & Illness: Gender, Power & the Body*. Thousand Oaks, CA: SAGE Publishers, pp. 121-139.

Steenland, K., Levine, A.J., Sieber, K., Schulte, P. & Aziz, D. (1997). "Incidence of tuberculosis infection among New York State prison employees." *American Journal of Public Health*, 87(12):2012-2017.

Stillion, J. (1995). "Premature death among males." In: D. Sabo & D. Gordon (Eds.). *Men's Health & Illness: Gender, Power & the Body*. Thousand Oaks, CA: SAGE Publishers, pp. 46-67.

Stillion, J. (1985). *Death and the Sexes: An Examination of Differential Longevity, Attitudes, Behaviors, and Coping Skills*. New York: Hemisphere Publishing.

Swedin, G. (1996) "Modern Swedish fatherhood: The challenges and the opportunities." *Reproductive Health Matters*, May (7):25-33.

Toepell, A. R. (1992). *Prisoners and AIDS: AIDS education needs assessment*. Toronto: John Howard Society of Metropolitan Toronto.

Verbrugge, L. M. (1988). "Unveiling higher morbidity for men: The story." In: M. W. Riley (Ed.), *Social Structures and Human Lives*. Newbury Park, CA: SAGE Publishers.

Verbrugge, L. M. (1985). "Gender and health: An update on hypotheses and evidence." *Journal of Health and Social Behavior*, 26:156-182.

Vlassoff, C. & Bonilla, E. (1994). "Gender-related differences in the impact of tropical disease on women: What do we know?" *Journal of Biosocial Science*, 26:37-53.

Waldron, I. (1983). "Sex differences in illness incidence, prognosis and mortality." *Social Science and Medicine*, 17:1107-1123.

Weeks, J. (1991). *Against Nature: Essays on History, Sexuality and Identity*. London: Rivers Oram Press.

West, C. & Zimmerman, D. (1987). "Doing gender." *Gender and Society*, 1:125-151.

Whitehead, M. (1992). "The concepts and principles of equity and health." *International Journal of Health Services*, 22(3):429-445.

Wolinsky, F. D. (1980). *The Sociology of Health; Principles, Professions, and Issues*. Boston: Little, Brown and Company.

Wyatt, G. E. & Dunn, K. M. (1991). "Examining predictors of sex guilt in multiethnic samples of women." *Archives of Sexual Behavior*, 20:471-85.

Zierler, S. & Krieger, N. (1997). "Reframing women's risk: Social inequalities and HIV infection." *Annual Review of Public Health*, 18:401-436.

Zill, N., Nord, C. W., & Loomis, L. S. (1995). *Adolescent time use and risky behavior and outcomes: An analysis of national data*. Rockville, MD: Westat, Inc.

Zambrana, J. (1997). *Impact of men's knowledge, attitudes and behaviors concerning family planning on the lives of women in Cochabamba*. La Paz: Family Health International and Cooperaziones Internacionales.

Harvard Center for Population and Development Studies
Working Paper Series

The following Working Papers are available from the Harvard Center for Population and Development Studies:

1999

No.99.14 D. Sabo
Understanding Men's Health: A Relational and Gender Sensitive Approach
August 1999

No.99.13 J. Broome
The Value of Living Longer
August 1999

No.99.12 K. Hanson
Measuring Up: Gender, Burden of Disease, and Priority Setting Techniques in the Health Sector
August 1999

No.99.11 J.M. Moravcsik
Health, Healing, and Their Values
July 1999

No.99.10 R.A. Allison, J.E. Foster
Measuring Health Inequality Using Qualitative Data
July 1999

No.99.09 F.M. Kamm
Deciding Whom to Help:
Resource Prioritization, Population Health Measures, and Disability
July 1999

No.99.08 P. Hartigan
Communicable Diseases, Gender, and Equity in Health
July 1999

No.99.07 A. Ratcliffe, A. Hill, G. Walraven
Two Sides to the Story: Male and Female Reproduction in the Gambia
July 1999

No.99.06 H. Standing
Frameworks for Understanding Gender Inequalities and Health Sector Reform:
An Analysis and Review of Policy Issues
June 1999

No.99.05 V. Adams
Equity of the Ineffable: Cultural and Political Constraints on
Ethnomedicine as a Health Problem in Contemporary Tibet
April 1999

No.99.04 A. Kleinman
Ethics and Experience: An Anthropological Approach to Health Equity
March 1999

No.99.03 P. Van Parijs
Just Health Care and the Two Solidarities
January 1999

No.99.02 T. Pogge
Justice in Health-Care: Reflections on the Foundations of Health Equity
January 1999

No.99.01 M. Marmot
Social Causes of Social Inequalities in Health
January 1999

1998

No.98.12 M. Majumdar, S. Subramanian
Capability Failure and Group Disparities: Measurement and Application
December 1998

No.98.11 C. Murray, J. Salomon
Using Mathematical Models to Evaluate Global Tuberculosis Control Strategies
October 1998

No.98.10 M. Das Gupta
Lifeboat Versus Corporate Ethic:
Social and Demographic Implications of Stem and Joint Families
June 1998

No.98.09 M. Majumdar
Child Labor as a Human Security Problem: Evidence from India
May 1998

No.98.08 A. Maharatna
Fertility, Mortality and Gender Bias Among Tribal Population:
An Indian Perspective
May 1998

No.98.07 J. Ribot
Rebellion, Representation and Enfranchisement in the Forest Villages of Makacoulibantang, Eastern Senegal
April 1998

No.98.06 J. Ribot
Decentralization and Participation in Sahelian Forestry:
Legal Instruments of Central Political-Administrative Control
April 1998

No.98.05 B. Steinbock
Rethinking the Right to Reproduce
April 1998

No.98.04 N. Eberstadt
What if It's a World Population Implosion?: Speculations About Global De-Population
March 1998

No.98.03 M. Das Gupta
"Missing Girls" in China, South Korea and India: Causes and Policy Implications
March 1998

No.98.02 M. McLean
Looking for Trouble: Breast and Cervical Cancer Screening Programs for Low-Income Women in the USA
January 1998

No.98.01 A. Maharatna
On Tribal Fertility in Late Nineteenth and Early Twentieth Century India
January 1998

1997

No.97.11 G. Martine, M. Villarreal
Gender and Sustainability: Re-Assessing Linkages and Issues
December 1997

No.97.10 H.G. Torres
Social Policies in the "Lost Decade": Evidence from the Case of São Paulo, Brazil
December 1997

No.97.09 P. David
Family-Building Patterns and Childhood Mortality: A Family-Level Analysis
December 1997

No.97.08 P. David
On Differentials in Family-Building Patterns
December 1997

No.97.07 G. Sen
Empowerment as an Approach to Poverty
December 1997

No.97.06 M. Das Gupta
Liberté, Egalité, Fraternité: Exploring the Role of Governance in Fertility Decline
December 1997

No.97.05 M. Das Gupta, L. Shuzhuo
Gender Bias and the "Marriage Squeeze" in China, South Korea and India 1920 - 1990: The Effects of War, Famine and Fertility Decline
November 1997

No.97.04 C. Naré, K. Katz, E. Tolley
Adolescents' Access to Reproductive Health and Family Planning Services in Dakar (Senegal)
August 1997

No.97.03 Z. Junming
Multilevel Analysis of Rural Outmigration in China
April 1997

No.97.02 A. Adams, T. Evans, R. Mohammed, J. Farnsworth
Socioeconomic Stratification by Wealth Ranking: Is it Valid?
April 1997

No.97.01 V. Shkolnikov
The Russian Health Crisis of the 1990s in Mortality Dimensions
March 1997

1996

No.96.08 S. Anand, J. Morduch
Poverty and the 'Population Problem'
December 1996

No.96.07 C. Murray, A. Acharya
Understanding DALYs
December 1996

No.96.06 S. Garcia, R. Snow, I. Aitken
Documenting Preferences for Contraceptive Attributes: Voices of Poor Women in Urban Colonias of Ciudad Juarez, Chihuahua, Mexico
November 1996

No.96.05 R. Snow, S. Garcia, N. Kureshy, R. Sadana, S. Singh, M. Becerra-Valdivia, S. Lancaster, M. Mofokeng, M. Hoffman, I. Aitken
Investigating Women's Preferences for Contraceptive Technology: Focus Group Data from 7 Countries
November 1996

No.96.04 P. Levitt
Social Remittances: A Conceptual Tool for Understanding Migration and Development
October 1996

No.96.03 M. Das Gupta, D. Narayana
Bangladesh's Fertility Decline from a Regional Perspective
April 1996

No.96.02 G. Martine
Population and Environment in the Current Development Scenario
April 1996

No.96.01 T. Evans, M. Rafi, J. Farnsworth, A. Adams, M. Chowdhury
Barriers to Participation in BRAC RDP
November 1995

1995

No.95.08 M. Das Gupta
Socio-Economic Status and Clustering of Child Deaths in Rural Punjab
December 1995

No.95.07 F.M. Knaul
Counting the Street Children of Bogota:
Defined Away, Missing or Out of Sight
October 1995

No.95.06 S. Anand, K. Hanson
Disability-Adjusted Life Years: A Critical Review
September 1995

No.95.05 S. Anand A. Sen
Gender Inequality in Human Development: Theories and Measurement
August 1995

No.95.04 G. Martine
Brazil's Remarkable Fertility Decline: A Fresh Look at Key Factors
July 1995

No.95.03 J.A. Adetunji
Infant Mortality Levels in Africa: Does Method of Estimation Matter?
June 1995

No.95.02 M. Das Gupta, M. Bhat
Intensified Gender Bias in India: A Consequence of Fertility Decline
May 1995

No.95.01 R. Bairagi, M. Shuaib, A. Hill
Progressive Estimation of Childhood Mortality:
The Preceding Birth Technique in Bangladesh
January 1995

1994

No.94.11 L. Chen, L. Hiebert
From Socialism to Private Markets: Vietnam's Health in Rapid Transition
October 1994

No.94.10 S. Bok
Complex Humanitarian Emergencies
October 1994

No.94.09 C. Murray, H. Sawert
Tuberculosis in the United States:
Strategies for Developing and Validating Models
August 1994

No.94.08 C. Murray, J. Kreuser, W. Whang
A Cost-Effectiveness Model for Allocating Health Sector Resources
July 1994

No.94.07 C. Murray, J. Bobadilla
Epidemiological Transitions in the Formerly Socialist Economies:
Divergent Patterns of Mortality and Causes of Death
June 1994

No.94.06 A. Sen
Population and Reasoning
June 1994

No.94.05 C. Ronsmans
Patterns of Clustering of Child Mortality in a Rural Area of Senegal
June 1994

No.94.04 S. Anand, A. Sen
Sustainable Human Development: Concepts and Priorities
March 1994

No.94.03 J.A. Adetunji
Infant Mortality and Mother's Education in Ondo State, Nigeria
March 1994

No.94.02 N. Eberstadt
Demographic Shocks in Eastern Germany, 1989-1993
February 1994

No.94.01 N. Eberstadt
Health and Mortality in Eastern Europe: Retrospect and Prospect
January 1994

1993

No.93.09 C. Murray, R. Govindaraj, G. Chellaraj
Global Domestic Expenditures in Health
December 1993

No.93.08 C. Michaud, C. Murray
Aid Flows to the Health Sector in Developing Countries:
A Detailed Analysis 1972-1990
December 1993

No.93.07 L. Chen, G. Berggren, S. Castle, W. Fitzgerald, C. Michaud, M. Simunovic
Sanctions in Haiti: Crisis in Humanitarian Action
November 1993

No.93.06 C. Murray, A. Lopez, D. Jamison
Global Burden of Disease in 1990:
Summary Results, Sensitivity Analysis and Future Directions
December 1993

No.93.05 C. Murray, A. Lopez
Quantifying the Burden of Disability: Data, Methods and Results
December 1993

No.93.04 C. Murray, A. Lopez
Global Cause of Death Patterns in 1990
December 1993

No.93.03 C. Murray
Quantifying the Burden of Disease:
The Technical Basis for Disability Adjusted Life Years
December 1993

No.93.02 S. Anand, C. Harris, O. Linton
On the Concept of Ultrapoverty
June 1993

No.93.01 W. Alonso, M. Waters
The Future Composition of the American Population: An Illustrative Projection
May 1993

1992

No.92.05 N. Eberstadt, J. Banister
Divided Korea: Demographic and Socio-Economic Issues for Reunification
December 1992

No.92.04 M. Garenne
Sex Differences in Measles Mortality: A World Review
August 1992

No.92.03 N. Eberstadt
Population and Labor Force in North Korea: Trends and Implications
March 1992

No.92.02 S. Hoffman
The Ethics of Humanitarian Intervention
February 1992

No.92.01 M. Das
The Internationalization of the Narmada Dam: Do Western Environmental Groups Have a Role in Third World Ecology Movements?
January 1992

1990-1991

No.91.08 T.N. Krishnan
Wages, Employment and Output in Interrelated Labour Markets in an Agrarian Economy: Kerala State, India
February 1991

No.91.07 R.J. Herring
Interests in Nature: Common Property, Dilemmas and the State
October 1991

No.91.06 C. Makhlouf Obermeyer
Women, Islam and Population: Is the Triangle Fateful?
July 1991

No.91.05 R.C. Snow, L.C. Chen
Towards an Appropriate Contraceptive Method Mix: Policy Analyses of Three Asian Countries
April 1991

No.91.04 N. Christakis, N. Ware, A. Kleinman
Illness Behavior and the Health Transition in the Developing World
February 1991

No.90.03 R. LeVine, S. LeVine, A. Richman, F. Uribe, C. Correa
Schooling and Survival: The Impact of Maternal Education on Health and Reproduction in the Third World
May 1990

No.90.02 L. Chen, C. Murray - ***No Longer in Circulation***
A Conceptual Approach to Morbidity in Health Transitions
November 1990

No.90.01 A. Sen
Objectivity and Position: Assessment of Health and Well-being
December 1990

Harvard Center for Population and Development Studies
Working Paper Series

To Order:

Mail To:

Name: _____

Address: _____

_____

_____

_____

_____

Telephone: _____

List of Publications:

No:	Author(s):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please Send US$2.50/individual, US$5.00/institutions for Each Paper to:

Working Paper Series
Harvard Center for
Population and Development Studies
9 Bow Street
Cambridge, MA 02138
USA

Telephone: 617 495-2022
Fax: 617 495-5418

Email: cpds@hsph.harvard.edu
Website: www.hsph.harvard.edu/hcpds

Please Make Checks Payable to Harvard University.

A Selection of the Harvard Center for Population and Development Studies Working Papers are now available online in a PDF format at: www.hsph.harvard.edu/Organizations/healthnet/